FMLA Leave to Care for Covered Servicemember **LEAVE REQUEST FORM**

To be completed by employee needing FMLA Leave to Care for a Covered Servicemember and submitted to the agency human resource contact. PLEASE PRINT LEGIBILY.

Employee Name_____

Mailing Address for Notices_____

eMail Address for Notices_____

Agency _____Class Title _____

Facility/Department/Unit/Section _____ Date of Hire _____

Supervisor _____ Date of oral notice, if applies_____

Documentation required to show (1) Employee's status as spouse, child, parent, or next of kin of (2) covered servicemember (3) who has a serious injury or illness. Employer is entitled to thirty (30) days' notice of foreseeable absences & documentation should be submitted prior to the start of the leave. Failure to submit such notice may result in leave being delayed. In emergency situations, Request & documentation should be submitted within fifteen (15) days from beginning of leave for an unforeseen absence.

TYPE OF LEAVE REQUESTED:

___Continuous

Date anticipate leave to start:_____ Date anticipate return to work: _____

___Intermittent

Provide description/details of medical necessity for and the estimated frequency and duration of absences for which Employee is requesting leave: (examples: "1-2 days per month for medical appointments OR "condition usually flares up 3-4 times per month for 1-2 days each and servicemember is incapacitated at these times").

_____

_____

___Reduced Hours

Identify proposed work schedule: (examples: "Tuesday/Wednesday/Thursday" OR "four (4) hours in morning" …) & medical necessity for such schedule.

_____

_____

REASON FOR LEAVE

Serious illness or injury of employee's SPOUSE, CHILD, PARENT, or NEXT OF KIN (Circle appropriate person) who is a covered servicemember.

*Does spouse / child / parent / next of kin reside with Employee? YES NO

*If FMLA is approved, all available sick leave will be charged concurrently with each FML absence for serious injury or illness of spouse, child, parent, or next of kin who resides with and is dependent upon the employee for care and support.

_____ _____

Signature of Employee *Date*

Received by:

_____ _____

Signature of HR contact *Date*

Eligibility: *12 months employment? YES NO*

1250 hours worked? YES NO

 # hours FML used this fiscal year = _____

HR Rep completing this section:

Initials/Date:_____